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Community Support – Adults (MH/SA)
Medicaid Billable Service

Service Definition and Required Components
Community Support consists of mental health and substance abuse rehabilitation services and supports necessary to assist the person in achieving and maintaining rehabilitative, sobriety, and recovery goals. This medically-necessary service directly addresses the recipient's diagnostic and clinical needs. These diagnostic and clinical needs are evidenced by the presence of a diagnosable mental illness and substance related disorder (as defined by the DSM-IVTR and its successors), with documentation of symptoms and effects reflected in the Person Centered Plan. Community Support services, which are psychoeducational and supportive in nature, are intended to meet the mental health or substance abuse needs of adults who have significant functional impairment that seriously interferes with or impedes his/her role or functioning in family, school or community.

The service is designed to:

- Increase skills to address the complex mental health and/or substance abuse need of adults who have significant functional deficits in order to promote symptom reduction
- assist the recipient in acquiring mental health/substance abuse recovery skills necessary to successfully address vocational, housing and educational needs.
- Assist the recipient in gaining access to and coordinating necessary services to promote clinical stability and to meet the mental health/substance abuse treatment, social, and other treatment support needs of the recipient

The rehabilitative service activities of Community Support consist of a variety of interventions that must directly relate to the recipient's diagnostic and clinical needs as reflected in a comprehensive clinical assessment and outlined in the Person Centered Plan.

These shall include as clinically indicated:
- identification of strengths which will aid the individual in their recovery as well as barriers that impede the development of skills necessary for independent functioning in the community
- one-on-one interventions, unless a group intervention is deemed more efficacious, with the recipient to develop interpersonal/relational and community coping skills, including adaptation to home, school, and work environments
- therapeutic mentoring that directly increases the acquisition of skills needed to accomplish the goals of the Person Centered Plan
- symptom monitoring
- medication monitoring with documented communication to prescribing physician(s)
- self-management of symptoms
- direct preventive and therapeutic interventions that will assist with skill building
- assistance with skill enhancement or acquisition
- relapse prevention and disease management strategies
- psychoeducation and training of family, unpaid caregivers, and others who have a legitimate role in addressing the needs identified in the Person Centered Plan

- support for ongoing treatment and encouraging the achievement of functional gains
- care management for the effective coordination of clinical service, natural and community supports for the recipient and his/her family

The service includes providing "first responder" crisis response on a 24/7/365 basis to consumers experiencing a crisis.

The Community Support Qualified Professional with the recipient initiates, develops, and revises the Person Centered Plan. The Community Support Qualified Professional provides coordination of movement across levels of care by interacting directly with the person and their family and by coordinating discharge planning and community re-entry following hospitalization, residential services, and other levels of care. The Community Support Qualified Professional provides and oversees case management to arrange, link, monitor, and/or integrate multiple services as well as assessment and reassessment (e.g., changes in life domains) of the recipient's need for services.

The Community Support Qualified Professional must consult with identified providers, include their input into the Person Centered Planning process, inform all involved stakeholders, and monitor the status of the recipient in relationship to the treatment goals. Community Support staff also inform the recipient about benefits, community resources, and services; and assist the recipient in accessing benefits and services. The organization assumes the roles of advocate, broker, coordinator, and monitor of the service delivery system on behalf of the recipient.

For Medicaid funded services, a personally signed service order for Community Support services must be completed by a physician, licensed psychologist, physician's assistant, or nurse practitioner, according to their scope of practice along with other documentation requirements outlined in this policy. The service order must be based on an individualized assessment of the recipient's needs. For State funded services, it is recommended that a service order is completed within the first visit.

Provider Requirements

Community Support services must be delivered by practitioners who are employed by mental health or substance abuse provider organizations that meet the provider qualification policies, procedures, and standards established by the Division of Medical Assistance and the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (MHDDSAS) and the requirements of 10A NCAC 27G. These policies and procedures set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. Provider organizations must demonstrate that they meet these standards by being endorsed by the Local Management Entity (LME). Within three years of enrollment as a provider, the organization must have achieved national accreditation with at least one of the designated accrediting agencies. The provider organization must be established as a legally constituted entity capable of meeting all of the requirements of the Provider Endorsement, Medicaid Enrollment Agreement, Medicaid Bulletins and service implementation standards. This includes national accreditation within the prescribed timeframe.

The Community Support provider organization is identified in Person Centered Plan. For Medicaid services, the organization is responsible for obtaining authorization from Medicaid's approved vendor for medically necessary services identified in the Person Centered Plan. For State funded services, the organization is responsible for obtaining authorization from the Local Management Entity. The

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Community Support provider organization must comply with all applicable federal, state, and DHHS requirements. This includes but not limited to DHHS Statutes, Rule, Policy, Implementation Updates, Medicaid Bulletins and other published instruction.

Staffing Requirements
Persons who meet the requirements specified (10A NCAC 27G.0104) for Qualified Professional (QP), Associate Professional (AP), or Paraprofessional status and who have the knowledge, skills, and abilities required by the population and age to be served, may deliver Community Support. Qualified Professionals shall develop and coordinate the Person Centered Plan. Associate Professionals and Paraprofessionals will deliver Community Support services to directly address the recipient's diagnostic and clinical needs under the direction of the Qualified Professional.

All Associate Professionals and Paraprofessionals providing Community Support must be supervised by a Qualified Professional. Supervision must be provided according to supervision requirements specified in 10A NCAC 27G.0204 and according to licensure or certification requirements of the appropriate discipline.

A Certified Clinical Supervisor (CCS) or Licensed Clinical Addiction Specialist (LCAS) may also deliver and supervise Community Support as a Qualified Professional.

The following chart sets forth the activities that can be performed by a Qualified Professional, Certified Clinical Supervisor, Licensed Clinical Addiction Specialist, Associate Professional, or Paraprofessional. These activities reflect the appropriate scope of practice for these individuals.

Qualified Professional Certified Clinical Supervisor Licensed Clinical Addiction Specialist	**Associate Professional Paraprofessional (under the supervision of the Qualified Professional)**
• Coordination and oversight of initial and ongoing assessment activities • Ensure linkage to the most clinically appropriate and effective service • Initial development and ongoing revision of Person Centered Plan including the involvement of the recipient and people identified as important in the recipient's life (e.g. family, friends, providers, etc) • Facilitate the Person Centered Planning process including the recipient and people identified as important in the recipient's life (e.g., family, friends, providers, etc.) • Monitoring the implementation of Person Centered Plan, including involvement of other medical and non-medical providers, the consumer, and natural and community	• Assisting with therapeutic interventions to rehabilitate: o Functional skills o Daily and community living skills o Adaptation, socialization, relational, and coping skills o Behavior and anger management skills o Self-management of symptoms • Therapeutic mentoring that directly increases the acquisition of skills needed to accomplish the goals of the Person Centered Plan • Psychoeducation and training of family, unpaid caregivers and others who have a legitimate role in addressing the needs identified in the Person-Centered Plan • Direct preventive and therapeutic interventions that will assist with skill building

supports • Supportive counseling to address the diagnostic and clinical needs of the recipient • Case management functions to arrange, link, monitor, and/or integrate multiple services and referrals • Coordination with the recipient's medical home (i.e., primary care physician) • Supervision of activities provided by Associate and Paraprofessional staff providing Community Support • Provision of all activities, functions, and interventions of the Community Support service definition	• Relapse prevention and disease management strategies • Ongoing symptom monitoring and management • Ongoing medication monitoring with report to medical providers • Service coordination activities within the established Person Centered Plan • Input into the Person Centered Plan modifications

All staff providing Community Support to adults must complete a minimum of 20 hours of training specific to the required components of the Community Support Service definition, including crisis response, within the first 90 days of employment.

Family members or legally responsible persons of the recipient may not provide these services for reimbursement.

Service Type/Setting
Community Support is a direct and indirect periodic service in which the Community Support staff provides direct clinical intervention and also arranges, coordinates, and monitors services on behalf of the recipient. Community Support providers must have the ability to deliver services in various environments, such as homes, schools, jails (for state funds only)*, homeless shelters, street locations and other community settings.

This service includes providing "first responder" crisis response on a 24/7/365 basis to consumers experiencing a crisis.

Community Support also includes telephone time with the individual recipient and collateral contact with persons who assist the recipient in meeting his or her rehabilitation goals. Community Support includes activities and meetings for the planning, development, and revision of the recipient's Person Centered Plan. Community Support services may be provided to an individual or a group of individuals.

***Note:** For all services, federal Medicaid regulations will deny Medicaid payment for services delivered to inmates of public correctional institutions or to patients in facilities that have more than 16 beds and that are classified as Institutions of Mental Diseases.

Program Requirements
Caseload size for a Community Support Qualified Professional may not exceed 1 Qualified Professional to 30 recipients. (Note: in computing caseload ratios, recipients receiving less than 4 hours of service per week may be counted as ½ recipient). When Community Support services are provided in a group, the group may not exceed eight individuals.

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The Qualified Professional shall provide a minimum of 25% of the total Community Support services provided per recipient during each authorization period. However, during the first authorized 40 units (10 hours) of Community Support service, the Qualified Professional shall provide a minimum of 50% of the units (5 hours) delivered: 1) to ensure prompt development and coordination of the required Person Centered Plan or 2) to ensure medically appropriate clinical interventions are provided based on implementation/revision of the required Person Centered Plan.

Program services are primarily delivered face-to-face with the recipient and in locations outside the agency's facility. The aggregate services that have been delivered by the agency will be assessed and documented annually by each provider agency using the following quality assurance benchmarks:

- All individuals receiving Community Support must receive a minimum of two contacts per month, with one contact occurring face-to-face with the recipient;
- a minimum of 60% of Community Support services that are delivered must be performed face-to-face with recipients; and
- a minimum of 60% of staff time must be spent working outside of the agency's facility with or on behalf of the recipients

Entrance Criteria
The recipient is eligible for this service when:

A. significant impairment is documented in at least two of the life domains related to the recipient's diagnosis which impedes the use of the skills necessary for independent functioning in the community. These life domains are as follows: emotional, social, safety, housing, medical/health, and legal.

AND

B. there is an Axis I or II MH/SA diagnosis (as defined by the DSM-IV-TR or its successors) other than a sole diagnosis of Developmental Disability

AND

C. American Society for Addiction Medicine (ASAM) criteria are met for recipients with a substance abuse diagnosis.

AND

D. the recipient is experiencing difficulties in at least **two** of the following criteria as evidenced by documentation of symptoms:
    1. is at risk for institutionalization, hospitalization, or is placed outside the natural living environment
    2. is receiving or needs crisis intervention services
    3. has unmet identified needs related to the MH/SA diagnosis for services from multiple agencies related to the life domains and needs advocacy and service coordination
    4. is abused or neglected as substantiated by DSS, or has established dependency as defined by DSS criteria
    5. exhibits intense verbal aggression as well as limited physical aggression to self or others, due to symptoms associated with diagnosis, that is sufficient to create functional problems in the home, community, job, school, etc.
    6. is in active recovery from substance abuse or dependency and is in need of continuing relapse prevention support

AND

E. there is no evidence to support that alternate interventions would be equally or more effective based on generally accepted North Carolina community practice standards (e.g., the American Society for Addiction Medicine, American Psychiatric Association) as available.

Entrance Process

Medicaid covers up to 4 unmanaged Qualified Professional hours for the purpose of collecting information to develop and initiate the required Person-Centered Plan. These unmanaged visits are only for recipients new to the service system and not to the provider. For other recipients, prior authorization is required.

For State funded Community Support services, prior authorization is required by the Local Management Entity.

Relevant diagnostic information must be obtained to complete the Person Centered Plan. This requirement may be fulfilled through the completion of any comprehensive clinical assessment service. If a substantially equivalent assessment is available that reflects the current level of functioning and contains all the required elements as outlined in community practice standards as well as in all applicable federal, state, and DHHS requirements, it can be utilized as a part of the current comprehensive clinical assessment.

For Medicaid, in order to facilitate a request for the initial authorization, the required Person Centered Plan with signatures and the required authorization request form must be submitted to the Medicaid-approved vendor.

For State funded Community Support, in order to facilitate a request for the initial authorization, the required Person Centered Plan with signatures, the required authorization request form and the Consumer Admission Form must be submitted to the Local Management Entity.

During the 4 unmanaged hours or at any point while receiving Community Support, the Qualified Professional shall link the recipient to an alternative service if an equally or more effective service is clinically indicated. The activities that led to the referral must be documented in the full daily service note.

Continued Stay Criteria

The desired outcome or level of functioning has not been restored, improved, or sustained over the time frame outlined in the recipient's Person Centered Plan; or the recipient continues to be at risk for relapse based on current clinical assessment, history, and the tenuous nature of the functional gains;-

AND

one of the following applies:

A. Recipient has achieved current Person Centered Plan goals but additional goals are indicated as evidenced by documented symptoms.

B. Recipient is making satisfactory progress toward meeting goals and documentation that continuation of this service will be effective in meeting the goals outlined in the Person Centered Plan.

C. Recipient is making some progress, but the Person Centered Plan (specific interventions) needs to be modified so that greater gains, which are consistent with the recipient's premorbid level of functioning, are possible or can be achieved.
D. Recipient fails to make progress and/or demonstrates regression in meeting goals through the strategies outlined in the Person Centered Plan. The recipient's diagnosis should be reassessed to identify any unrecognized co-occurring disorders with treatment recommendations revised based on findings.

Discharge Criteria
Any one of the following applies:
A. Recipient's level of functioning has improved with respect to the goals outlined in the Person Centered Plan, inclusive of a transition plan to step down
B. Recipient has achieved positive life outcomes that support stable and ongoing recovery and is no longer in need of Community Support services.
C. Recipient is not making progress or is regressing and all reasonable strategies and interventions have been exhausted, indicating a need for more intensive services.
D. Recipient or legally responsible person no longer wishes to receive Community Support services.
E. Recipient, based on presentation and failure to show improvement despite modifications in the Person Centered Plan, requires a more appropriate best practice treatment modality based on North Carolina community practice standards (e.g., National Institute of Drug Abuse, American Psychiatric Association).

Note: Any denial, reduction, suspension, or termination of service requires notification to the recipient and/or legally responsible person in accordance with the Department's recipient notices procedure.

Expected Clinical Outcomes
The expected clinical outcomes for this service are specific to recommendations resulting from clinical assessments and meeting the identified goals in the recipient's Person Centered Plan.

Expected clinical outcomes may include:
- Maintain recovery
- Reduce symptoms
- Increased coping skills and social skills that mediate life stresses resulting from the recipient's diagnostic and clinical needs
- Minimize the negative effects of psychiatric symptoms and/or substance dependence that interfere with the recipient's daily living
- Uses natural and social supports
- Utilize functional skills to live independently
- Develop and utilize strategies and supportive interventions for stable living arrangements (avoidance of out-of-home placements)

Documentation Requirements
The minimum standard is a daily full service note written and signed by the person who provided the service that includes:

- the recipient's name
- Medicaid identification number
- the service provided (e.g., Community Support – Individual or Group)
- date of service
- place of service
- type of contact (face-to-face, phone call, collateral)
- purpose of the contact-
- a description of the provider's interventions-
- the amount of time spent performing the interventions
- a description of the effectiveness of the interventions
- the signature and credentials of the staff member(s) providing the service (For paraprofessionals, position is required in lieu of credentials with staff signature).

Refer to DMA Clinical Policies and DMH/DD/SAS Records Management and Documentation Manual for a complete listing of documentation requirements.

Utilization Management
Services are based upon a finding of medical necessity, must be directly related to the recipient's diagnostic and clinical needs, and are expected to achieve the specific rehabilitative goals specified in the individual's Person Centered Plan. Medical necessity is determined by generally accepted North Carolina community practice standards as verified by independent Medicaid consultants or the Local Management Entity for State funded services.

If the needed medical information is not yet completed when the initial prior authorization request is submitted, the appointment date(s) and historical clinical information should be included. Interim prior authorizations with variable timelines for resubmission will be given to ensure the delivery of needed services.

Medically necessary service is authorized in the most economic mode, as long as the treatment that is made available is similarly efficacious to services requested by the recipient's physician, therapist, or other licensed practitioner.

For Medicaid, authorization by the approved vendor is required according to published policy.

For State funded Community Support services, authorization is required by the Local Management Entity prior to the first visit. The Medicaid-approved vendor or the Local Management Entity will evaluate the request to determine if medical necessity supports more or less intensive services.

Medicaid covers up to 780 units up to a 90-day period, based on the medical necessity documented in the required Person Centered Plan and supporting documentation. Community Support services are not

intended to remain at this level of intensity long term. If the initial benefit of 780 units is expended before the end of the 90-day period, the required Person Centered Plan and a new ITR must be submitted to the Medicaid-approved vendor to request additional units and/or equally or more effective clinically alternate services.

For State funded services, the Local Management Entity will determine the initial authorization period. The required Person Centered Plan, an ITR, and supporting documentation reflecting the appropriate level of care and service must be submitted to the Local Management Entity.

Additional units may be authorized on a time-limited basis to allow time for the Qualified Professional to coordinate for alternative services.

If continued Community Support services are needed at the end of the initial authorization period, the required Person Centered Plan and a new ITR reflecting the appropriate level of care and service must be submitted to the approved Medicaid services or the Local Management Entity for State funded services. This should occur prior to the expiration of the authorization.

Units are billed in 15 minute increments with the required modifier designating the level of the staff providing the service.

Service Exclusions/Limitations
An individual can receive Community Support services from only one Community Support provider organization at a time.

Community Support services can be provided for individuals residing in adult mental health residential facilities independent living; supervised living low or moderate; and group living low, moderate, or high).

For the purpose of transitioning a recipient to and from a service (e.g., facilitating an admission to a service and/or discharge planning) and to ensure that the service provider works directly with the Community Support Qualified Professional, Community Support-Individual services can be provided by the Qualified Professional and billed for a maximum of 8 units for a 30-day period for individuals who are authorized to receive one of the following services:

- Assertive Community Treatment Team
- Community Support Team

For the purpose of transitioning a recipient to and from a service (e.g.., facilitating an admission to a service and/or discharge planning), providing coordination during the provision of a service, and to ensure that the service provider works directly with the Community Support Qualified Professional, Community Support-Individual services can be provided by the Qualified Professional and billed for a maximum of 8 units for each 30-day period for individuals who are authorized to receive one of the following services:

- Substance Abuse Intensive Outpatient Program
- Substance Abuse Comprehensive Outpatient Program

For the purpose of transitioning a recipient to and from a service (e.g., facilitating an admission to a service and/or discharge planning), providing coordination during the provision of a service, and to ensure

that the service provider works directly with the Community Support Qualified Professional, Community Support-Individual services can be provided by the Qualified Professional and billed in accordance with the authorization for services during the same authorization period for the following services based on medical necessity:

- All Detoxification Services
- Professional Treatment Services in Facility-Based Crisis Programs
- Partial Hospitalization
- Psychosocial Rehabilitation
- Substance Abuse Medically Monitored Community Residential Treatment
- Substance Abuse Non-Medically Monitored Community Residential Treatment

Note: For recipients under the age of 21, additional products, services, or procedures may be requested even if they do not appear in the N.C. State Plan or when coverage is limited to those over 21 years of age. Service limitations on scope, amount, or frequency described in the coverage policy may not apply if the product, service, or procedure is medically necessary.